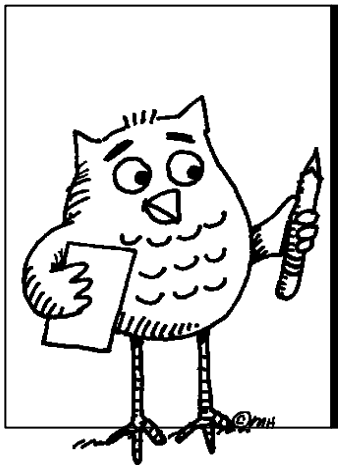

Waiver Wise

Technical Assistance for the Community Options Program Waiver COP-W

Wisconsin Department of Health & Family Services • Division of Supportive Living
Bureau of Aging & Long Term Care Resources

Volume 01 Issue 11

Oldies but Goodies II – Commonly Asked Questions

The following is the second installment in a series of technical assistance documents that will focus strictly on frequently asked questions. The information included in this document addresses general health services questions.

Question 1 - Can CIP II/COP-W funds be used to pay the initial cost of a health club/YMCA membership and the subsequent monthly membership fee at the health club/YMCA for a participant? If so, what SPC should be used and what criteria would need to be considered when authorizing this?

Yes. Under SPC 507 – Counseling/Therapeutic Resources, the costs associated with joining a health club or YWCA may be an allowable expenditure if certain criteria are met. These criteria include the following:

- There must be a stated therapeutic goal directly related to the participant's health or disability. In other words, documentation should be obtained from the participant's medical doctor that the exercise programs, pool, and/or whirlpool facilities meet therapeutic goals to either maintain or improve a medical condition.

- There must be documentation the costs cannot be paid by Medicaid.

- The instructors/trainers of the exercise program or swim therapy must meet the standards outlined in the Medicaid Waivers Manual.

In addition, the effectiveness of the program and/or the commitment of the participant in attending the health club/YMCA should be reviewed on a regular basis by the care manager. In the event waiver funds are to be used, the county should pursue payment to the health club/YMCA for the services on a sliding fee scale, if available. Please note that if a sliding fee scale is not available or the facility will not apply it to the participant, waiver funds can still be utilized.

Note: If a Group B or C participant pays the membership fee at a health club/YMCA with their own money, this cost could be counted as a medical/remedial expense.

Question 2 – As a follow up question, when a participant attends a health club/YMCA or participates in a water therapy class, what standards should be applied and how should this be documented within the case file?

Because this service falls under SPC 507, the standards listed on page 115 in the Medicaid Waivers Manual apply. However, the care manager should have some additional information within the file as well. As described above, there should be documentation from the participant's medical doctor that participation in an exercise or water therapy program meets a therapeutic goal. With regard to meeting the standards for the various instructors, the care manager should obtain or see a copy of a certificate that indicates the instructor is trained to meet the participant's stated therapeutic goal. Care managers can either obtain a copy of the instructor's current certificate and place it in the participant's file, or if the care manager sees the instructor's certificate and confirms that it is current, the care manager can document within the case notes that the instructor has met the standards.

Question 3 – Can waiver funds be used to purchase or repair eyeglasses? Sometimes eyeglasses have been denied by Medicaid because the glasses themselves have additional components to them as a result of the participant's medical condition (e.g. amber lens, extra wide glasses, trifocals, very strong prescription, etc.).

Yes, if a written denial from Medicaid has been obtained, waiver funds can pay for eyeglasses under SPC 112.55 – Specialized Medical Supplies.

If a participant needs a second pair of eyeglasses to meet a need, the need has to be documented and a written denial for the second pair of eyeglasses must be obtained. Please note: Waiver funds can only pay for Medicaid allowable frames.

Note: If a Group B or C participant pays the cost of eyeglasses with their own money, this cost can be counted as a medical/remedial expense.

Question 4 – Can waiver funds be used to purchase items (Nicorette gum or "the patch") prescribed by a participant's physician to aid in the participant's efforts to quit smoking? Can waiver funds be used to pay for over the counter smoking cessation kits that can be purchased at a drug store? Can waiver funds be used for acupuncture or hypnotism to help a participant quit smoking?

Yes, under SPC 112.55 – Specialized Medical Supplies, waiver funds can be used to pay for over the counter smoking cessation kits sold at local drug stores, "the patch," or Nicorette gum if they are part of a treatment plan designed by the participant's doctor to aid in helping the participant quit smoking. The care manager needs to document that Medicaid cannot pay for the items and should obtain a statement from the physician indicating that the items are needed. In addition, the effectiveness of the items and/or the commitment of the participant in using the items should be reviewed on a regular basis by the care manager.

Some participants have utilized an acupuncturist to help quit smoking. Waiver funds can be used to pay for acupuncture (SPC 507) if certain criteria are met. Please see the previously distributed Technical Assistance Document Volume 01 Issue 06 – Question 6 for information on the criteria. When acupuncture is used to assist a participant to stop

smoking, the care manager should review the effectiveness of the treatment and/or the commitment of the participant on a regular basis.

It is not allowable to use waiver funds to pay for a participant to be hypnotized. It is too difficult to ensure that standards have been met.

Note: If a Group B or C participant pays the cost of the "patch", nicorette gum, over the counter smoking cessation kits, or an acupuncturist with their own money, these costs could be counted as a medical/remedial expense.

Question 5 – Can waiver funds be used to purchase exercise equipment?

Yes. Under SPC 112.55 – Specialized Medical Supplies, exercise equipment may be waiver allowable if the following criteria are met.

- The participant's medical doctor must provide information to indicate the exercise equipment is needed to improve and/or maintain the participant's health.

- There needs to be documentation that Medicaid will not fund the item.

In addition, the care manager should discuss the participant's commitment in using the piece of equipment, available space to keep the equipment, and how often it will be used. Also, the county may wish to research other more cost effective venues to meet this need (i.e. a membership at the YMCA in which there would be access to various pieces of exercise equipment).

Lastly, it is best practice to confer with either an OT or PT to obtain information regarding the proper use of the exercise equipment in order for the participant to achieve or meet the stated therapeutic goal.

Question 6 – Can waiver funds be used to pay for routine foot cares? If so, under what SPC would foot care fall?

It is important to remember that Medicaid will pay for routine foot care whether the foot care is provided during an office visit or in the participant's home. The provider of the foot care only needs to be an Medicaid provider, and the participant has to have one of the diagnoses listed in the WMAP Provider Handbook, Part V. As a result, it is important to utilize a podiatrist that accepts Medicaid. If the participant requires an attendant to accompany them to their appointment, waiver funds can be used to pay for the attendant time. Medicaid should pay the costs involved in providing the actual transportation.

In addition, Medicaid funds foot care as a service under the tasks a personal care worker can perform.

However, if Medicaid has denied this service, waiver funds can be used when **routine foot care is defined as foot cleaning, nail cutting, and/or nail trimming.** Any type of foot care that goes beyond these three things is not waiver allowable. With this information in mind:

- The waiver program can fund routine foot care provided by a supportive home care worker under SPC 104 – Supportive Home Care if Medicaid funding of this service

has been explored and is unavailable (i.e. the participant does not receive on-going personal care services funded by Medicaid). The care manager should assure the SHC worker has received adequate training on foot care. The SHC worker would be paid the usual and customary fee or contract rate.

- The waiver program can fund foot care provided by a nurse under SPC 710 – Nursing Services if Medicaid funding of this service has been explored and has been denied. The rate billed for the service would be the usual and customary fee for a nursing visit.

Question 7 -- Can waiver funds be used to purchase a gait belt?

Yes. Because the gait belt is used to assist a participant with ambulating, it is seen as an Adaptive Aid – SPC 112.99. The care manager needs to document that Medicaid funds are not available. Also, as good practice, the care manager may wish to consult with a medical professional to ensure the gait belt is the appropriate device needed. It is also important to remember that caregivers may need to be instructed in the correct way to utilize the gait belt.

Question 8 – Can waiver funds be used to pay for dental services?

This is an excellent question because it gets at the heart of a what appears to be happening more frequently – medical professionals that are Medicaid providers but who are unwilling to accept Medicaid because they feel the reimbursement rate is too low, or who are unwilling to accept new patients who utilize Medicaid. As a result, counties are asked to pay for services that should be funded by Medicaid.

While it is true that several years ago, HCFA made a decision that Medicaid would no longer pay for dentures, we know this decision was reversed. When HCFA originally decided to no longer pay for dentures, BALTCR allowed waiver funds to be used to pay for dentures, partial plates, and the realignment of dentures and plates. In addition a dental bridge would also be waiver allowable if it could be documented that a bridge is necessary and that a partial will not work for a participant. It was felt these types of dental work related to an adaptive device that assisted the participant in eating, which is an activity of daily living. Because of this, these items are waiver allowable as SPC 112.99 – Adaptive Aids.

However, since HCFA reversed their decision, Medicaid will pay for dentures, partial plates, and the realignment of dentures and plates. As a result, Medicaid should be utilized first. It is the expectation that care managers work with the participant to obtain the needed dental work and have it covered by Medicaid. If there is no dentist in the area accepting Medicaid (for whatever reason) or taking new patients, waiver funds can be used to pay the cost of an attendant to accompany the participant to the dentist in a neighboring community if need be. Medicaid should pay the actual cost of the transportation. As a point of information, if a care manager becomes aware of an Medicaid provider who will not accept Medicaid, they may contact the following for assistance and direction:

a) Division of Health Care Finance – Bureau of Fee-for-Service Care Benefits at (608) 266-0510, or
b) the Wisconsin Medicaid Professional Relations Representative in your area.

In the event a written, formal Medicaid denial is obtained, waiver funds can be used to pay for dentures, partial plates, and the realignment of dentures and plates. In addition a dental bridge would also be waiver allowable if it could be documented that the bridge is necessary and that a partial will not work for the participant. This is allowable under SPC 112.99 – Adaptive Aids. The price for the dental work should be a customary fee, including all the related dental work needed to have the work completed, with the exception of tooth extractions which Medicaid will fund.

Note: Waiver funds never have, nor do they currently pay for the following dental services: examinations, routine teeth cleaning, x-rays, extractions, root canals, caps, jackets, crowns and most bridges.

In addition, there is a program called the Donated Dental Services (DDS) program. Through this program, dentists throughout the state have volunteered to donate comprehensive dental care to people of all ages, who, because of a serious disability, advanced age, or medical problems, do not have enough income to pay for needed dental care. There are no rigid financial eligibility requirements for this program. In general, there are no costs to qualifying individuals. However, people in a position to pay for part of their care may be encouraged to do so, especially when laboratory work is involved. People should complete an application and mail it to the Donated Dental Services, PO Box 658, Milwaukee, WI 53201.